

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

6341

63

025603

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<b>FILED JUN 21 1963</b>		<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Louis</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>3-mos.</b>		c. CITY OR TOWN <b>Unincorporated</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Edgewater Nurs. Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>11369 Five Oaks Parkway</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>William Adamski</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>June 14, 1963</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1/18/70</b>	<b>9. AGE (last birthday)</b> <b>93</b>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>retired</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>-----</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Warsaw, Poland</b>	
<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>		<b>13a. FATHER'S NAME</b> <b>----- Adamski</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>unknown</b>	
<b>14. NAME OF HUSBAND OR WIFE</b> <b>Julia</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>-----</b>					
<b>17. INFORMANT</b> Address <b>Mrs. A. Wiese-11369 Five Oaks Pk.</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for: (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>151 X</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Generalized arteriosclerosis</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year					
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE		
<b>21. I attended the deceased from</b> <b>March 16, 1963</b> to <b>June 14, 1963</b> and last saw him alive on <b>June 14, 1963</b> Death occurred at <b>4:25 P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
<b>22a. SIGNATURE</b> <b>Robert J. Sanders, M.D.</b> (Degree or title)			<b>22b. ADDRESS</b> <b>5500 S. Broadway</b>		<b>22c. DATE SIGNED</b> <b>6-14-63</b>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>	<b>23b. DATE</b> <b>June 17, 1963</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Resurrection Cem.</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis County, Missouri</b>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>WACKER-HELDERLE-3634 Gravois Ave.</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>JUN 17 1963</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Loan Smith, M.D.</b>	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

Licensed Embalmer No. 4375

P. O. Address St. Louis 14, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license):

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.